UROLOGY SPECIALISTS, P.C.

William R. Chapman, III, M.D. James A. Flatt, M.D.
Michael W. Brown, M.D. V. Keith Jiminez, M.D.

**NEW PATIENT INFORMATION** (PLEASE PRINT & COMPLETE IN FULL) DATE_____

LAST NAME_____ FIRST NAME_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

REFERRING PHYSICIAN_____ FAMILY PHYSICIAN_____

BUSINESS PHONE_____ CELL PHONE_____ SPOUSE'S NAME_____

DATE OF BIRTH_____ SEX_____ MARITAL STATUS_____ SS#_____

RACE_____ ETHNICITY_____ LANGUAGE_____

E-MAIL ADDRESS_____ EMPLOYER_____

Name of nearest relative, outside your home to notify in case of emergency:

_____ Relationship_____ PHONE_____

PRIMARY MEDICAL INSURANCE CO._____ POLICY #_____

NAME OF POLICYHOLDER_____ RELATIONSHIP TO YOU_____

INSURED DATE OF BIRTH_____ INSURED SS#_____ GROUP #_____

SECONDARY MEDICAL INSURANCE CO._____ POLICY #_____

NAME OF POLICYHOLDER_____ RELATIONSHIP TO YOU_____

INSURED DATE OF BIRTH_____ INSURED SS#_____ GROUP #_____

PHARMACY_____

***Patients are seen in order of appointments, as much as possible. Occasionally, it may appear that someone is being seen "out of turn". This occurs because the doctors, of necessity, must spend more time in consultation with new patients, and this may affect the normal patient flow. We will try to make your wait as short as possible and your understanding is appreciated.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical information necessary to process any insurance claim on my behalf. A photo-stat of this authorization shall be considered as valid as the original.

SIGNED: _____

I authorize payment to Urology Specialists, P.C. benefits otherwise payable to me. I understand that I am financially responsible to those indicated above for charges not covered by this authorization. I also agree that, should I fail to assume this financial responsibility and credit action is necessary. I will pay for these costs in addition to the amount of the doctor's charges.
I acknowledge and agree that Urology Specialists, P.C. and any affiliates or vender thereof, including collection or billing companies, may contact me by telephone or text message number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Urology Specialists, P.C. if I have given up ownership or control of any such telephone number.

SIGNED:_____

4704 Whitesburg Drive Huntsville, AL 35802 (256) 882.3605 Fax (256) 880-1272 2010

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Receipt of Privacy Practices: Consent for Use/Disclosure of Protected of Health Information (PHI)

I, _____ was provided a copy of Urology Specialists' Privacy Practices Notification. Urology Specialists may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand, and agree to the terms of this consent. Further, I hereby consent and authorize Urology Specialists to use or disclose my PHI in conjunction with Urology Specialists' treatment, payment or healthcare operations in accordance with the terms of this consent.

➔ _____ _____

Signature of Patient/Guardian Date

Further, I hereby authorize and give my consent to Urology Specialists to leave messages on my answering machine/voicemail/e-mail for the following: (*check all that apply*)

| | | | |
|---|---|---|---|
| Appointment Reminders | _____ | Prescription Refills | _____ |
| Medical Information | _____ | Test Results | _____ |
| Insurance/Payment Issues | _____ | Mail | _____ |

I further authorize and give consent to Urology Specialists to communicate any of my PHI to the following person/persons:

| Name | Relationship |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

➔ _____ _____

Signature of Patient/Guardian Date

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## Unpaid Co-Payment Process Fee Acknowledgment and Appointment Authorization Agreement

Our physicians hold a responsibility to recommend what treatment you may need. Any recommendations are based off of your history, any testing, labs and office exam by our office. Your physician and nurse will give you any options available for the treatment and thoroughly answer any questions you may have.

This form serves as notification of a specialist co-pay that each insurance REQUIRES Urology Specialists to collect at the time of service in the amount of _____. If you feel that this amount is incorrect and/or has changed, it is the responsibility of the patient to provide Urology Specialists' staff with the correct amount and insurance information. This co-pay amount is an estimated cost and may be more or less as will be determined by your insurance company. Also, there is no guarantee of payment for procedures and visits performed. Any denial of this will result in financial responsibility of the office visit and any procedures to fall upon the patient and will require payment of the amount in its entirety.

IF you are unable to pay Urology Specialists the co-pay as listed in your individual insurance policy today, you claim awareness to be billed for the co-pay plus an additional processing fee of $15.00* as specified in our billing process. If chronic non-payment occurs it will constitute a hold on the account and pre-payment to the account before the next visit will be scheduled.

Some insurance require a prior-authorization from the insurance company itself and the lack the authorization or referral required as noted in the individual policy will result in non-payment from the insurance company. If your insurance requires an authorization or a referral, it is THE PATIENT'S responsibility to ensure this is received in a timely fashion. Stating this, financial responsibility of the office visit and any procedures will fall upon the patient and will require payment of the amount in its entirety if a denial is received for lack of authorization. If any questions arise regarding a bill, contact Urology Specialists' billing department at 256-882-3626.

I authorize the release of any medical information necessary to process any insurance claim on my behalf. A photo-stat of this authorization shall be considered as valid as the original.

We are not part of the relationship you have with your insurance company. If your insurance company denies coverage for your benefit for any reason, you will obtain responsibility to become financially responsible for the amount due.

I understand that I am financially responsible for a fee if I no show for my appointment or cancel without giving a minimum of a business day (24 hours) notice. I also agree and understand that should I fail to give notice as instructed that the account may be subject to a $25.00 charge* for a regular appointment and $50.00 charge* for a procedure appointment. Multiple no-show or cancellations may result in dismissal from the practice.

Patients are seen in order of appointments, as much as possible. Occasionally, it may appear that someone is being seen "out of turn". This occurs because the doctors, of necessity, must spend more time in consultation with new patients, and this may affect the normal patient flow. We will try to make your wait as short as possible and your understanding is appreciated.

➔ _____ _____

Signature of Patient/Guardian Date

*This is subject to the change and is at the discretion of the office.

# Urology Specialists, PC

Michael Brown, MD ~ William Chapman, MD ~ James Flatt, MD ~ Keith Jiminez, MD

## Patient Portal

To participate, please fill out this form.

Name: _____

Date of Birth: _____

Email address: _____

We will email you with further instructions to complete this system.

4704 Whitesburg Drive, Ste 100 Huntsville, AL 35802 256.882.3605

Initial Patient Visit -**History and Physical**

# Urology Specialists, P.C.

**William Chapman, M.D. Michael Brown, M.D. James Flatt, M.D. Keith Jiminez, M.D.**

Please fill out items 1-13

**1. Name** _____ Age _____ Date of Birth ____/____/____ Today's Date ____/____/____

**2. History of Present Illness:** (location, quality, severity, duration timing). State the reason(s) you are seeing a urologist. How long has this problem(s) been going on?

_____

_____

_____

_____

_____

_____

_____

HPI: For Physician Use Only (Backslash = negative)

_____

_____

_____

___ Freq _____

___ Urg _____

___ Noct __ x _____

___ Dysuria _____

___ Incontinence ____ pads/day _____

___ Obst sx's: straining dribbling intermittency split stream

**3. Genitourinary History / ROS:** Check if you now have or have had any of the following:

- ❑ Blood in your urine
- ❑ Painful Urination
- ❑ Passage of kidney stones: number ___
- ❑ Sexual Dysfunction
- ❑ Leaking urine
- ❑ Pain over your bladder
- ❑ Catheter placed b/c of inability to urinate

**4. Medical History:** Please check all conditions you have been diagnosed with and/or treated for. Give any necessary details or discuss any other conditions not listed on the following lines **OR** ❑I have no serious medical conditions.

- ❑ **Diabetes**
- ❑ **High blood pressure**
- ❑ **HIV/ AIDS**
- ❑ **Anemia**
- ❑ **Cancer (list what type below)**
- ❑ **Other (Please explain below)**
- ❑ **Kidney disease**
- ❑ **Kidney stones**
- ❑ **Kidney failure**
- ❑ **Emphysema**
- ❑ **Bronchitis**
- ❑ **Lung disease other**_____
- ❑ **Heart disease**
- ❑ **Heart attack**
- ❑ **Congestive heart failure**
- ❑ **Stroke or other vascular disease**
- ❑ **Poor circulation**
- ❑ **Blood clots**
- ❑ **Sexually transmitted disease**
- ❑ **Herpes**
- ❑ **Gonorrhea**
- ❑ **Condyloma**
- ❑ **Liver disease**
- ❑ **Cirrhosis**
- ❑ **Hepatitis**

_____

_____

(If unchecked then PMHx is normal)

**5. Pregnancy History:** _____ No. of pregnancies: _____ No. of vaginal deliveries _____No. of Caeserean sections

**6. Are you ALLERGIC to any medications?**

_____

_____

_____

_____

❑ I have no known medication allergies

**7. List your MEDICATIONS & dosages.** (including over the counter, such as aspirin):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

❑ Coumadin ❑ Plavix

**8. Past Surgical History:** Check all the operations you have had:

- ❑ Cystocopy by urologist
- ❑ Hysterectomy - ovaries remain
- ❑ Hysterectomy - ovaries removed
- ❑ Heart valve replaced
- ❑ Heart bypass
- ❑ Kidney stone removal
- ❑ Hernia Repair
- ❑ Colon removal
- ❑ Appendectomy
- ❑ Joint replacement
- ❑ Other cancer surgery (list below)
- ❑ Other surgery (please explain)

❑ Any blood transfusions? _____

**9. Social History:**

Occupation:_____

Do you smoke? ❑No; ❑Yes, _____ packs/day for ____ years: ❑ Quit

How much alcohol do you drink? ❑None; _____ drinks/week;

How much caffeine do you drink a day? _____coffee; _____ soda; ____ tea

**10. Family History:** Does anyone in your family have:

❑ Heart disease, ❑ Diabetes; ❑ Kidney stones; ❑ Kidney disease

❑ Prostate cancer; ❑ other cancer, please explain: _____

**11. Review of Systems - Check if you now have or have had any problems related to the following systems:** ( If unchecked then normal)

| Constitutional Symptoms | Psychologic | Musculoskeletal | Neurological | Eyes | |
|---|---|---|---|---|---|
| ❑ Weight loss<br>❑ Weight gain<br>❑ Fever | ❑ Depression<br>❑ Anxiousness | ❑ Joint pain | ❑ Stroke | ❑Glaucoma<br>❑Cataract | |
| **Gastrointestinal** | **Cardiovascular** | **Respiratory** | **Hematologic** | | |
| ❑ Abdominal pain<br>❑ Nausea/vomiting | ❑ Chest pain<br>❑ Irregular heartbeat | ❑ Shortness of breath<br>❑ Asthma | ❑ Blood clotting problems | | ❑ ROS reviewed with pt --no significant findings |

**Urology Specialists, P.C.** **H&P page II** Patient Name_____ Chart # _____ Pert.

**12. AUA symptom score**

| Circle the number that best describes your voiding symptoms over the past month: | Not at All | <1 in 5 | Less than 1/2 the time | 1/2 the time | More than 1/2 the time | Almost always | |
|---|---|---|---|---|---|---|---|
| 1. How often have you had a sensation of not emptying your bladder completely? | 0 | 1 | 2 | 3 | 4 | 5 | Inad empt |
| 2. How often have you had a weak urinary stream? | 0 | 1 | 2 | 3 | 4 | 5 | Weak str |
| 3. How often have you had to push or strain to begin urination? | 0 | 1 | 2 | 3 | 4 | 5 | Straining |
| 4. How often have you had to stop and start again when you urinate? | 0 | 1 | 2 | 3 | 4 | 5 | Intermit. |
| 5. How often have you had to urinate less than 2 hours after you finish urinating? | 0 | 1 | 2 | 3 | 4 | 5 | Freq. |
| 6. How often have you found it difficult to postpone urination? | 0 | 1 | 2 | 3 | 4 | 5 | Urg. |
| 7. How many times do you typically get up to urinate at night? | 0 | 1 | 2 | 3 | 4 | 5 | Noct. |
| | | | | | SUM | _____ | |

**13. Who referred you to Urology Specialists?** _____
☐ Check if self referred

**** For Physician use only below this line****

T _____ Wt _____lbs.
P _____ BP _____/_____

| pH | Glu | Pro | Nit | Bld | L.E. |
|---|---|---|---|---|---|
| SG | Ket | Epi | Bact | RBC | WBC |

**PE (check if normal or no abnormality; circle if abnormal and describe)**

| | | | |
|---|---|---|---|
| Constitutional | ☐ Gen appear- normal | | ☐ Vital signs reviewed |
| Skin | ☐ Inspection/palpation | Neck | ☐ Normal |
| Neurologic | ☐ Orientation | Lymphatic | ☐ No abnorm. in neck and groin |
| Respiratory | ☐ Effort normal | | ☐ Ausc - no abn. |
| CV | ☐ Reg rate and rhythm | | ☐ Ausc - no abn. |

GI ☐ Abd soft and nontender ☐ Liv/Kid/Spln nonpalpable
☐ No hernia ☐ Stool specimen not indicated

**GU Male**
☐ Urethral meatus
☐ Penis ____circ ____ uncirc
☐ Testes/ Scrotum
☐ Epididymis; ☐ cyst
☐ Anus/perin
☐ Sphincter tone
☐ Sem. Ves.
☐ Prostate ( )
Smooth, no nodules
1+ 2+ 3+

**GU Female**
☐ Ext genitalia
☐ Urethral Meatus
☐ Urethra
☐ Vagina
☐ Cervix ☐ absent
☐ Uterus ☐ absent
☐ Bladder
☐ Anus/perin
☐ Rectal

Notes / Abnormalities:

☐ BI Scan: _____ cc (PVR)
☐ KUB: _____
☐ No Ca++ or abnorm. noted

**IMPRESSION:**
1. _____
2. _____
3. _____
4. _____

**PLAN:**
1. _____
2. _____
3. _____

Rx: _____ Samples given: _____

**Labs**
☐ Urine Cx
☐ Cytol
☐ PSA
☐ PSA II
☐ BUN / cr
☐ Testost

**Imaging**
☐ IVP
☐ CT UTS
☐ Renal US

**Procedures Planned**
☐ Cysto
☐ Prostate biopsy

☐ New Pt ☐ Consult | I II III IV V | Time: _____ min | ☐ Chapman ☐ Brown ☐ Flatt ☐ Jiminez

☐ Dictated Note ☐ Dictated Letter to Dr._____ Physician Signature _____

**Urology Specialists, PC**
**4704 Whitesburg Drive, Suite 100**
**Huntsville AL 35801**
**Phone (256) 882-3605** **Fax (256) 880-1272**
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**William R, Chapman , M.D.** **V. Keith Jiminez, M.D., F.A.C.S**

_____
Name of Patient

# Extra Visit History

Have you had a colonoscopy within the last 9 (nine) years? YES or NO

If so, when was it (PLEASE FILL OUT DATE) _____

Have you ever had a pneumonia shot? YES or NO

If so, when was it (PLEASE FILL OUT DATE) _____

I acknowledge that the above is filled out to its entirety and holds true for my medical and surgical history. If the above differs in the future, I will make the office aware at my next office visit so the appropriate changes can be made.

_____ _____
Signature of Patient Date